TRAC Meeting Minutes

April 10, 2003

Topic	Discussion	Actions/Decisions
Attendees:	Steve Rich, Diana Webster, Lynette Sharp, Murry Sturkie, Steve Millard, Chris Marselle Joesph Morris, Neill Piland, Bob Seehusen, Randy Cordle, Dana Meyers, Boni Carrell, Dia Gainor, John Cramer, Richard Schultz	
Welcome and Introduction	Steve Millard chaired. Introductions.	
Review Minutes 12-17-02		Minutes approved.
Inclusion criteria	*Answer questions that surfaced during the data element subcommittee meetings.* Boni introduced definitions and criteria inclusion document. Criteria has not been discussed at any point in TRACs efforts. Awareness of these criteria came about upon review of the Utah system. Discussion about excluding 960 – suicide from toxic substances and bioterrorism. How do biological substances and trauma relate? If such an event occurred, wouldn't have time to collect data. Alternate systems will be developed for bio-terrorism events. Tendency is to want to collect everything. Keep it narrow, can expand later. Q. Could this be a good tool to measure utilization and mis-utilization of emergency care and effects of medical error? A. Focus of this group, which was designed by Legislation, is to evaluate trauma care. Objective of this discussion is to make sure everyone is aware of what would be left out. The sub-committee's biggest concern was the exclusion of suicides from toxic substances. Would this be useful information or would it dilute the numbers? This document is based on the ACS definitions of trauma. Cordle stated that there needs to be a better definition of 760.5. Maternal injury – fetus or newborn affected by maternal conditions classifiable to 800-995.	Motion to accept the inclusion document based on ACS trauma definitions with the inclusion of 760.5 - Maternal Injury was seconded and passed. The 760.5 diagnosis will be researched and may be revisited if needed on 6/12.

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Hospital Capacity Survey	*Understand the resources currently available within the hospitals. Begin identifying additional resources needed.* Boni presented the Hospital Capacity Survey results. The survey was sent out by IHA. The objective is to develop strategies and resources to close the gap between available and needed resources. The survey was designed to assess current capabilities and identify the registry related needs of each Idaho hospital. Based on results we're able to analyze data in 4 different groups: a) Overall, b) less than 20 traumas per month, c) greater than 20, and d) hospitals currently using a registry. There are 39 hospitals in Idaho that would be involved. 26 hospitals returned surveys. The group was uncertain whether the survey gave adequate information to determine potential costs. There was a suggestion to determine a per event reimbursement rate. It was stated that a per event rate would not fund initial startup costs such as infrastructure, internet, hardware, software, etc. The survey identified potential additional FTE requirements. There is data about FTE and coding speed ratios. A reimbursement fee might be based on this ratio. Different methods of extracting the data were mentioned. Chris stated that in order for a hospital to keep its ACS designation, the coding had to be done by the hospital. However, the hospital is not restricted from receiving reimbursement for the activity. The group asked that we don't ask the hospitals for more information than is needed for the project. There were concerns about how the hospitals could give valid information in the survey without a registry of some type. Need useful information gather was about patient transfers and FTE/coding event ratio. It was suggested that we don't ask the hospitals what they need to implement the registry. A different information gathering method such as expert team onsite visits might be useful.	More survey returns are expected and will be incorporated into the survey results. Feedback about the results will be sent to responding hospitals.

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Proposed Data Elements	Chris and Lynette, sub-committee co-chairs, presented. Members of sub-committee: Steve Rich, Murry Sturkie, Dana Meyers, Boni Carrell, Dia Gainor, John Cramer, Leslie Tengelsen, Ginger Floerchinger-Franks Every element is a need to know. Started with 488 data elements. Verified and tested each element against selection parameters or functional necessity. Current data elements: 52 collected by hospitals, 91 for registry. Difference between 52 & 91: Some are contributed by others sources and linked to the registry or calculated by the system. Won't be a dynamic linkage, but periodic at specified reporting periods. HIPPA implications: public health registries are exempt. Can share data. Hospitals are required to maintain disclosure information for 6 years. Record is de-identified. Can't access a single complete record. Aggregate data only. Public health data bases are exempt from getting disclosure statements, but the hospitals admitting patients do. Mandatory reporting is exempt, but for voluntary submission HIPPA may be required. The trauma registry is mandatory. The only HIPPA required field is date of birth. Data sets are adult oriented. Dr. Cordle was adamant about including schools in the incident location. Utah registry has school and playground specificity. There were several suggestions to capture this information. 1) Add one digit to the coding to specify. This would still be compliant with national reporting standards. It was noted that the location of injury field is a multi item pick list. Adding digits is more than adding numerals. This would be a customization. Is TRACS modifiable? 2) New data element for schools. Yes/No. 3) Occupation element: Q. What is the value of including occupation for adults? A. Worker's compensation issues. Add student to the	**Motions** Approve data elements as presented by the sub-committee. Seconded. Amend hospital data dictionary, extend to a thousandth digit to report location. Both motions were withdrawn. Motion to accept proposed data elements with the exception of incident location (schools, military installations and reservations) and pediatric trauma score elements which need further information about feasibility and practicality. Motion withdrawn. Chair will ask the sub-committee to meet again and consider today's suggestions and bring recommendation to next meeting.

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	occupation field. 4) EMS run report has 22 fields for location, one of which is education. Through linkage to EMS run reports would identify educational facility. Whatever solution is implemented, the method for determining additional elements needs to use the same methodology, parameters & functionality tests as the other elements. Pediatric organizations, who are contributing to this project, will be interested in pediatric specific focus. Legislative mandate states that pediatric information will be collected. Reality check. Can add more data points. Where's the maximum number? What is reasonable? Specificity can be accomplished by adding element or modifying fields. Which is the most efficient? Further suggestions 1. Consider military installations and Indian reservations. 2. Define 13 – GPS location. Use atomic clocks for time. 3. Define control in 31 – respiratory rate controlled. 4. Temperature – define how taken. 5. Pediatric specific information is Glasgow score. 6. 52-56 - What is the value of discharge Glasgow score. Need some kind of outcome score. Glasgow isn't a meaningful measure. Disability outcome score? Are the hospitals utilizing other assessments – FIM. It was suggested to use cost based research to get a handle on expected costs. Use DRG diagnosis group and code patient diagnosis and use Medicare allowable amount for that diagnosis so there is a standard charge. Data on how to do cost research would give us guidance. Cost/charge ratios might be a valid measure.	Subcommittee will exclude Ecodes that are not in the IC9 set to shorten pick list.

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Reporting Format	*Identify a process to accomplish the selection of a reporting format including time frames for reporting.* Identification of steps or decisions related to inputting of data, a flowchart of process and resources, is necessary to develop an adequate RFP that will identify specific characteristics of software and technology. Survey indicates there is a low interest in sending in the entire deidentified chart to be abstracted off site. Although a totally electronic method is very desirable and efficient, a paper (form or scannable sheet) method must also be considered for the use of small, low trauma volume hospitals. Cordle favored a Web based system because information must be provided before the user can continue the process and paper forms have greater error rate. Questions to be answered are how data will be relayed with a transfer patient to the receiving hospital and how to eliminate duplication of data entry. Relational database should be able to match by identifier field. Q. Does it really matter the method if the data gets submitted? A. Dia: The Bureau's experience with Patient Care reports is that the expectations need to be clearly defined. Millard also has experience with the Cancer registry. Personnel goes out to the hospitals to input the data so that there is current data. There is a fee for this activity. Abstracting from existing databases is difficult. Don't want to interfere with existing hospital systems. Goal: What's the most cost effective way to get to the desired outcome of quality accurate data in a timely manner? There are two aspects: 1) Getting facility to use the system. (mandate); and 2) Quality Assurance is different from utilization. Staff turnover, training are issues. This discussion needs to determine the participation level of committee, sub-committee or Bureau.	Identified Absolutes: 1. Electronic. 2. Paper option. 3. Abstracters. Train. Gather data. Check validity. Project sent to EMS Bureau staff

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Evaluation of Progress	Dana Meyers distributed a meeting evaluation form. This is a grant requirement.	
Set Next Agenda	Window of opportunity for federal grant is usually July to September. EMSC grant cycle is March to February. Concern that cost is going to be greater than fund resources. FTE has already been identified as an invalid cost assessment. What is the cost of other states' systems? Utah pays $10 for copy of chart according to 2001 information. Cost will depend on method and skills. Can determine a per chart cost by using the number of traumas identified in the survey and determine a reasonable reimbursement according to known available funds and then negotiate with the hospitals. Boni can use a list serve to ascertain what other states are reimbursing for the same type service. Hospitals that use TRACs or other registry tools have developed processes. Could learn from that experience. Q. If funding doesn't allow data collection from all hospitals, might need to only collect from larger hospitals. A. Legislation states that "each licensed hospital will report each case of trauma and that there will be no increased costs to the hospitals. Q. Could have a sliding scale. Aren't we assuming that all hospitals are of equal need? Some of the RMCs already have systems. A. Schultz: Need to give equal reimbursement. Can't go facility by facility, day by day, this is not good management. Q. Could this have charitable contribution status? A. Miniscule compared to other subsidized operations.	June 12, 2003 1. Proposed data elements of sub-committee update. 2. Committee Evaluation results 3. Hospital Capacity survey update. 4. Reporting Format. Promulgation Draft Rules 5. What is This Going to Cost? Assess Ongoing Funding.